

# Balance Disorder Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referring Physician \_\_\_\_\_

1) Briefly describe the problem you are encountering: \_\_\_\_\_

\_\_\_\_\_

2) Have you consulted any other physician regarding your dizziness? Y N

If yes, please list and describe findings: \_\_\_\_\_

\_\_\_\_\_

3) Has any testing been performed to assist in the diagnosis?.....Y N

If yes, please list: \_\_\_\_\_

## Dizziness History

1) Is your dizziness a sensation of: (Please Circle)

a. Turning..... Y N

b. Lightheadedness.....Y N

c. Disorientation.....Y N

d. Loss of Balance..... Y N

e. Room Spinning..... Y N

f. Is your dizziness different than these listed?..... Y N

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

2) When did your dizziness begin? \_\_\_\_\_

3) Did it happen: Suddenly? Gradually?

4) Can you recall what you were doing when the dizziness first occurred?..... Y N

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

5) Was it accompanied by: Nausea? Vomiting?

6) Do you know of anything that may have caused or been related to your dizziness?..... Y N

If yes, please describe: \_\_\_\_\_

- 7) Is your dizziness: Continuous? Periodic?
- 8) Are you dizzy right now? .....Y N
- 9) When did the last attack occur? \_\_\_\_\_
- 10) Is the dizziness brought on or made worse by sudden movement or change in position? ...Y N
- If yes, please describe the positions and changes that take place: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- 11) How long does a typical attack last? \_\_\_\_\_
- 12) Have your symptoms changed over the past 6 weeks? \_\_\_\_\_
- 13) Rate your Dizziness on a scale of 1-10 (1 – no dizziness; 10 – worst): \_\_\_\_\_

- 14) Have you experienced any of the following:
- |                                       |                                    |
|---------------------------------------|------------------------------------|
| a. Headache .....Y N                  | h. Loss of memory .....Y N         |
| b. Pressure in head.....Y N           | i. Difficult concentrating ...Y N  |
| c. Pressure in back or neck ..... Y N | j. Shortness of breath..... Y N    |
| d. Numbness in face..... Y N          | k. Loss of energy .....Y N         |
| e. Blurred vision .....Y N            | l. Fear of falling .....Y N        |
| f. Fainting spell.....Y N             | m. Tingling in face or hands...Y N |
| g. Chest pain .....Y N                |                                    |

- 15) Are there any factors that make your dizziness worse? .....Y N
- If yes, please describe: \_\_\_\_\_
- 16) Are there any factors that make your dizziness better? .....Y N
- If yes, please describe: \_\_\_\_\_

### Hearing

- 1) Do you have a hearing loss: .....Y N
- If yes, please describe: \_\_\_\_\_
- 2) Did your hearing loss begin at the same time as your dizziness? .....Y N
- 3) Was your hearing loss: Sudden? Gradual?
- 4) Does your hearing fluctuate? .....Y N
- 5) Is there or have you had any pressure in your ears?.....Y N
- 6) Is there any pain in your ears?..... Y N
- 7) Have you had a history of ear infections? .....Y N

- 8) Have you had your hearing tested previously by an audiologist? .....Y      N  
If yes, what were the results? \_\_\_\_\_  
\_\_\_\_\_
- 9) Do you wear hearing aids? .....Y      N  
If yes, what type: \_\_\_\_\_  
\_\_\_\_\_

**General History**

- 1) Have you ever had a head or ear injury?.....Y      N  
If yes, please answer the following questions:  
a. Have you ever had surgery to your head or ears? .....Y      N  
b. Did you have a concussion? .....Y      N  
c. Were you knocked out (unconscious)? .....Y      N  
d. Did you feel dizzy? .....Y      N
- 2) Have you been exposed to excessive noise (machinery, gunfire, etc.)? .....Y      N
- 3) Have you now, or in the past, had any of the following illnesses?  
a. Diabetes .....Y      N                      g. Mumps .....Y      N  
b. High Blood Pressure.....Y      N                      h. Measles .....Y      N  
c. Heart Disease .....Y      N                      i. High Fever .....Y      N  
d. Stroke .....Y      N                      j. Seizure Disorder .....Y      N  
e. Kidney Failure .....Y      N                      k. Migraine Headaches .....Y      N  
f. Glaucoma .....Y      N
- 4) Any other illnesses? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 5) Please list all medications you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for taking the time to fill out this questionnaire to enable us to serve you better!*